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## **Refugees and Resiliency An Inter-professional Planning and Learning Tool**

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# Refugees And Resiliency

## An Inter-professional Planning and Learning Tool

A Trauma-Informed Lens

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University of Dundee

in partnership with the One World Centre



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# PART 1: BACKGROUND INFORMATION

## Introduction

The development of the inter-professional planning framework is the result of a collaboration between the One World Centre and the University of Dundee. Both organisations are acutely aware of the breadth and depth of need of refugees who are coming to Scotland and the limited resources in place to respond to such need. The idea of an inter-professional planning framework was to give both single agencies, as well as agencies working together, a quick accessible way of identifying and beginning to respond to diverse and complex needs for refugees. Given the war-torn contexts many refugees will be coming from, a particular focus of the planning framework is child and family traumatisation and how best to facilitate child, family and community resiliency. The planning tool is in three parts: 1. Background information; 2. How to use the Planning Framework; and 3. The Planning Framework.

## Aims of the inter-professional planning tool

This inter-professional planning framework is an adaptation and extension of the National Child Traumatic Stress Network planning tool. This has been adapted to fit with Scottish Government policy. The framework aims to enable statutory and non-statutory agencies in Scotland be aware of the nature of traumatisation and resultant symptomology that may be experienced by child and adolescent refugees and their families. The content of the planning framework includes: defining the status of refugees; the trajectory of traumatic events that refugees can experience; understanding the triggering nature of trauma; how trauma impacts on children and adolescents; screening and assessment of trauma; empirically-based interventions; support groups; resources and career long professional learning sessions and workshops.

The framework can be used and adapted by individual agencies or a cluster of agencies to help plan to meet the needs of refugees and their families in a systematic way. It is a standalone, but can also be used alongside current procedures and practice. The tool will also help collect information for writing feedback or reports to other agencies. Finally the framework aims to provide a structured approach for workers and organisations to identify and plan to meet their learning needs. The planning framework is downloadable in digital form from [www.icctpr.com](http://www.icctpr.com) and [www.oneworldcentre.org.uk](http://www.oneworldcentre.org.uk).

## Scottish policy context

The Scottish Government website states the following:

Scotland has a long history of welcoming refugees and asylum seekers and recognises it is a human right to be able to seek asylum in another country. Immigration and asylum are reserved issues and are the responsibility of the UK Government's Home Office. The UK is a signatory to the [1951 Convention Relating to the Status of Refugees](#) and is obliged to

consider properly any application for asylum made by a person who claims to be fleeing persecution. Some people seeking asylum are moved to Scotland as part of the UK Government's dispersal policy within the [Immigration and Asylum Act 1999](#).

The Scottish Government is responsible for devolved issues which relate to integration of refugees and asylum seekers in Scottish communities. This includes initiatives, such as English language classes and translation assistance, and services such as health care and education. <http://www.gov.scot/Topics/People/Equality/Refugees-asylum>

## Definitions and status

The United Nations uses the following definitions for refugees, migrants, asylum seekers, stateless persons and unaccompanied minors.

“A **refugee** is a person who has fled his or her own country and cannot return due to fear of persecution, and has been given refugee status. Refugee status is given to applicants by the United Nations or by a third party country, such as Australia. According to the *United Nations Convention relating to the Status of Refugees*, as amended by its 1967 Protocol (the Refugee Convention), a **refugee** is a person who is:

- outside their own country and
- has a well-founded fear of persecution due to his/ her race, religion, nationality, member of a particular social group or political opinion, and is
- unable or unwilling to return.

The United Nations High Commission for Refugees (UNHCR) estimated that at the end of 2012 there were 15.4 million refugees in the world.”

“A **migrant** is someone who voluntarily chooses to leave his or her own country and make a new life in another country. Australia has a long history of migration. People have been moving to Australia for work and better opportunities since British colonisation in 1788.”

“An **asylum seeker** is a person who has fled from his or her own country due to fear of persecution and has applied for (legal and physical) protection in another country but has not yet had their claim for protection assessed. A person remains an asylum seeker until their protection ‘status’ has been determined.”

“A **stateless person** is someone who does not have a nationality recognised by any country, for example, Palestinian people living in Palestine/Israel, Kurds in Syria or ethnic Chinese living in Brunei.”

“In immigration law **unaccompanied minors**, also known as separated **children**, are generally **defined** as foreign nationals or stateless persons below the age of 18, who arrive on the territory of a state, **unaccompanied** by a responsible adult, and for as long as they are not effectively taken into care of such a person.”

[http://www.roads-to-refuge.com.au/whois/whois\\_definitions.html#refugees](http://www.roads-to-refuge.com.au/whois/whois_definitions.html#refugees)

Children, adolescents and their families coming to Scotland will fit many of the above definitions. It will be important for local authorities and the various stakeholders, statutory and non-statutory, to understand the legal and Scottish Government policy context including rights and responsibilities of refugees and the communities in which they live. The core principle is that the child's wellbeing is paramount.

## Responding to refugee traumatisatisation and resiliency:

### Some core questions?

Many children and families may fit the above definitions/categories, and as such, supporting and helping refugees who come into Dundee, Perth and Kinross, Angus and Fife will involve a diversity of challenges. Most, if not all, will belong to cultures and families very different from the local Scottish context. A range of differing beliefs may be held on a wide range of factors, such as gender, class, ethnicity as well as beliefs about healing, spiritual healing and the stigma of mental illness. To be supportive, there is a need to first understand the culture that refugees come from and how this has shaped their world view and their interpretation of behaviour. Below is a series of starter questions to consider.

*What is the geographical or climatic context from where the families have come?* A Bedouin family who have lived in the desert, for example, is likely to find a Scottish city or rural farm setting alien and strange. What do we take for granted that is likely to be a stressor for refugee children and families? What do they need to know about our geographical communities and our ever-changing climate?

*What is the refugee's understanding of the concept of family?* For example, in some parts of the Middle East, families are more akin to the Scottish clans, some may be as large as 5000. Elders can be revered and the thought of care homes would be an anathema to them. What might this mean for a dislocated 'family group' or indeed 'unaccompanied minor' (a child who may have lost parents or all their family) in an increasingly individualistic society?

*How do the meanings of words differ across languages and cultures?* For example, there may not be words that match the words we have for something, or there may be nuances of understanding that are important but don't get spotted, leading to confusion or offence. What are these words, and what confusion and frustration might they cause?

*What might be some of the challenges of working with interpreters?* For example, what do you do if the interpreter and family chat away as if you are not there? How do you know if what you have said, or the family have said, has been explained properly? How can you check out the family's experience of the interpreter?

*How do the refugees understand the concept of trauma?* In the West, we tend to hold an individualistic view of traumatisatisation. In contrast, many of the traumas experienced by refugees have been collective and occurred over many years within contexts of war. Solutions to trauma are therefore often seen at family and community levels rather than through individual therapy.

*How do the expression of trauma symptoms differ across cultures?* For example, in some countries in the Middle East children are far less likely to show their distress through behaviour and more likely to show distress through physical symptoms and complaints. This can be a result of a taboo on mental health, where odd behaviour could be labelled negatively as someone being ‘crazy’. We, therefore, may need to be open to a different emphasis in symptoms that may indicate traumatising. What are the symptoms children are showing? How similar or different are they to trauma symptoms in the West? (See sections on symptoms of trauma and trauma across the age range)

*Are children familiar with sharing their thoughts and feelings?* For example, children’s voices may not be recognised as important, with most decisions made by the head of a household, clan/ community or school leader. We may need to be aware that it may take time before children and their families understand that children’s voices are important in Scottish culture. To what extent are children given a voice? If children’s voices are heard at all, how is this done within their culture?

*Is receiving help experienced as a stigma?* For example, the concept of healing may be connected to the concept of God or Allah and therefore spiritual healing may make more sense than going to the doctor, or even more alien going to the psychologist or psychiatrist. What we may experience as resistance to help may be a difference in cultural understandings about what help is. What are the refugee families’ understanding of mental health and trauma? What stigma might there be to accepting help?

*And what culturally sensitive issues need to be explored for each person and family?* Assumptions cannot be made because of the wide diversity of experiences and beliefs within and between families, communities and societies. As such it is recommended that the above questions are explored with each individual refugee and family to begin to understand their world view and where the incongruities are within a local Scottish context.

## What is a traumatic event?

The trauma lens shifts the perspective from symptoms to what has happened to children and families, in order to understand their symptoms. Many of the children and families who are refugees will have experienced a range of traumatic events. Traumatic events can be a single event, such as being in or witnessing a serious road traffic accident or a missile attack. Single events can be small *t* traumas, such as a put down comment or big *T* traumas such as a bomb blast. Traumatic events can come in clusters of events, such as the sudden and traumatic loss of a murdered relative, dispossession of one’s home and the witnessing of someone being assaulted. Traumatic events or experiences can also be over a long period of time. This could involve experiencing the acts of war over many years, if not generations. Such war events may be individually experienced or they may be part of collective trauma events. Unfortunately, acts of domestic violence also appears to be higher within families in war-torn contexts.



### *Trafficked children*

Trafficked children experience a wide range of traumatic events including sexual exploitation, domestic servitude, and/or forced labour including drug running in their home country, en route to Scotland or within Scotland. Within such situations of adversity and modern day slavery, children experience a myriad of cumulative traumas and loss as well as neglect of their most basic needs. Children are groomed and terrified and some struggle to psychologically accept that they have been coerced and/or violently forced into being trafficked. Trafficked children are likely to have ongoing vulnerabilities from the abuse of power, coercion, violence and trauma experienced that can result in future victimisation or some the victimisation of others.

### *Unaccompanied minors*

Unaccompanied minors are children who have no parent or guardian in this country. In addition to the traumas listed above, they will have lost parents, siblings and extended family though war, disaster or during the journey to Scotland. Unaccompanied minors can experience a myriad of harms including homelessness, hunger and destitution, grooming by criminal networks, prostitution, and living on the streets. It is not uncommon for unaccompanied minors to ‘disappear’.

Trafficked and unaccompanied children are less likely than other children to receive advice and consistent support. Their wide ranging needs include financial assistance, legal representation, child protection and welfare support and procedures, health care, and housing. It will be important that children’s views are heard, and that they will have a caring adult to support them through the process of coming to live in Scotland and settling into the community including help with language and literacy and any disability.

### *Children of disputed age*

Trafficked children and unaccompanied minors can experience the additional confusion and trauma caused by lack of documentation. Different countries identify different legal ages for childhood, and in some cultures the concept of chronological age is an odd one. Problems have occurred where assessment of age has been done from physical presentation and even medical examination alone is not sufficient. Where the legal age of a child is disputed, the child needs a legal advisor and a lawful age assessment.

### *Case study: Abraham from Libya*

*Abraham was born in Bengazi, Libya and had a relatively safe and happy childhood until the civil war broke out. Abraham was seven. Life changed overnight when the fighting started. Abraham would lie in bed night after night, terrified as he heard planes overhead drop their bombs. At times he’d feel his home shake with the size of the blasts. Tragically for Abraham, one of the missiles landed on his home. He had been out at school at the time. His mother and father, however, had been at home with their baby – all died. Abraham was told of what happened at school. He couldn’t believe it. The nightmares and bedwetting started then. Abraham kept imagining what happened to his mum, dad and baby sister in the blast. Although Abraham was taken into his aunt’s home and family, this was short lived as brutal street to street fighting led Abraham and his extended*

*family to flee the city. It seems like they walked for months. Sleeping out in the bitter cold each night. Finally they reached .... In the confusion at the boats, Abraham was separated from his aunt. He was terrified. After what seemed like weeks at sea, the boat arrived in Italy. It was chaotic, people were screaming, babies were crying, men were fighting. Abraham was exhausted and remained terrified.*

## Trajectories of traumatic events for refugees?

The trajectories of traumatic experience can be understood as involving five different parts to the refugee journey, that is, the past history of trauma, the journey en route to Scotland, the arrival in the UK and Scotland, the post-migratory stressors and the wide range of cumulative losses that refugees will experience throughout the journey. Examples of potential traumas experienced at each part of the journey are detailed below:

- *Past history of trauma* – historic war events; collective war events such as missile attacks and bomb blasts, intergenerational trauma (from the experience of living with traumatised parents) and past daily aggression, e.g. witnessing killings; killing others (child soldiers); torture; detention; sexual exploitation; physical assaults; slavery; and abusive/neglectful parenting etc.
- *En route to Scotland* – witnessing/experiencing violence; deprivation of basic needs; incarcerated; uncertainty; multiple losses; placed in detention and detention shame; physical punishment; sexual harassment; abused in detention; and drug dealers violence.
- *On arrival to Scotland* - unpredictable asylum procedures; language difficulties; and being treated with mistrust.
- *Post-migratory stressors* - accessing housing, education and benefits and entitlements - income, clothing, medical and psychological services; transportation problems; not feeling trusted; racism/discrimination; maintaining services and supports; and struggling to feel part of school.
- *Cumulative T losses* – family; friends; home; identity; status; culture; language; customs; and feelings of isolation.

## Trauma as a triggered response

Following a traumatic event, sensory fragments of the original trauma are hot-wired at a neurobiological level. Images, sounds, smells, tastes and body sensations are stored as traumatic memory, which is then triggered when a traumatic reminder occurs in the child's environment. For example a child may have been traumatised by a bomb blast. In Scotland a car may back-fire. This loud bang (a sensory fragment of the original event) triggers the traumatic memory. The child then experiences the blinding flash of the bomb she saw at the time, smells the sulphur, tastes the grit in her mouth, and feels pain and deafness in her ears.

She is not ‘remembering’ the event, she is re-experiencing the event. It is happening all over again in all its sensory vividness and horror and terror. If there have been many events there are likely to be many triggers, which could be occurring daily, weekly, monthly or many times a day. Not surprisingly some children refuse to leave their homes.

### *Case study: Saleh from Syria*

*Saleh’s town had been flattened following weeks of bombing. His body couldn’t cope with any kind of loud bang. Although he was safe in Scotland, he suddenly and unexpectedly heard fireworks going off. For Saleh, however, his body reacted like a bomb went off. He found himself curled in a ball on the ground, holding himself. His body was shaking and there were tears in his eyes. He couldn’t let go of his legs. He had a strange smell in his nostrils, he felt sick and heard screaming voices in his head.*

### What are the symptoms of trauma?

Symptoms as a result of traumatic events, experience or stressors have tended to be understood within the concept of post-traumatic stress disorder. Symptoms typically involve:

- (i) flashbacks of the original event(s) and intrusions of sounds, smells and body sensations
- (i) hyper-arousal involving terror, fear and anxiety, difficulties sleeping, being easily startled and
- (ii) avoidance such as numbing, dissociation, avoiding people and places, and talking about the traumatic events

More recently trauma symptoms, especially from contexts of ongoing adversity such as domestic violence and war, are seen as more pervasive. Bessel van der Kolk has developed the concept of developmental trauma in children that equates closely to complex trauma in adults who have experienced lifetimes of abuse and harm. Signs and symptoms can include:

- (i) hopelessness about the future
- (ii) belief in the world as a bad place
- (iii) self-harm
- (iv) substance misuse
- (v) a hardening of the heart for self and others, being victimised or victimising others, depression, sadness and crying
- (vi) dissociative problems such as not remembering traumatic events, not feeling oneself or experiencing the world as solid, body pains
- (vii) problems occur with relationships at home, in school and in the community
- (viii) problematic behaviour including violence, gang related behaviour, stealing and vandalism
- (ix) difficulties in regulating overwhelming feelings of fear and terror.

- (x) Finally, it is important to raise awareness of the risk of suicide for refugee children. A recent study identified around a third of children in the general population in the UK have had suicidal thoughts. While there are no clear statistics for child refugees in the UK, there is good reason to believe child refugees are at greater risk of suicidal thoughts, attempted suicide and suicide.

Some of the signs to be watchful of are: previous suicide attempts; depression; self-harm; previous detention; family history of suicide; substance misuse; unemployment; and unresolved anger and history of aggression. Appendix 1 provides further signs of risk as well as protective factors.

*Protective measures* for suicide include: having a strong faith, good family relationships, one's own cultural identity, inviting and inclusive school and peer communities; responsive social and health care services; involvement in hobbies, leisure and clubs; and achievements in school and community (see agencies section for suicide prevention agencies).

Some may show one sign, a cluster of signs or no signs at all. Trauma can be a delayed response with symptoms presenting at a point in the future when the child/adult feels safe enough to experience the symptoms.

## Trauma across the age range?

There are no hard and fast signs for each period of development; however the following lists highlight the patterns of signs that can occur.

### *Pre-school*

Children who are of pre-school age may show their trauma and distress through play and behavioural signs. This can include:

- Regressive or repetitive play
- Regressive or repetitive behaviour, e.g. thumb sucking, refusing to separate from parents
- Avoiding playing with others
- Bedwetting and nightmares
- Aggression towards peers and temper tantrum

### *Primary school*

Primary aged children tend to show difficulties in learning, behaviour, and relationships. These can include:

- Aggression and violence towards peers
- Becoming withdrawn from peers and activities
- Separation anxiety and fear that something bad will happen
- Crying and sadness
- Difficulties with concentration and learning
- Getting into trouble more frequently for bad behaviour

### *Secondary school*

By secondary, signs of distress and trauma can appear more pervasive because of the developing internal and external worlds of adolescence. Signs can include:

- Feeling guilty and shame
- A sense of hopelessness with difficulties envisioning a better future
- Substance misuse
- Self-harm
- Relationship problems in home, school and community
- Getting involved in criminality such as stealing and vandalism
- Absconding from home and school

### *Parent/Adults*

- PTSD including flashbacks, anxiety/fear and avoidance of traumatic reminders
- Complex trauma including substance misuse, depression, dissociation and numbing, self-harm, attempted suicide, relationship problems, concentration problems, difficulties at work, inability to work, guilt and unresolved grief.

### *Case study: Rahimah and mother from Syria*

*Rahimah was twelve. Her father had been killed fighting in Syria and her mother seemed distant and rarely spoke these days. Rahimah thought everything would be ok once the two of them arrived in Scotland and she had her own bedroom, but she still hears her mum crying most nights. Mum also gets angry suddenly for the smallest reasons, and for the first time in Rahimah's life her mother slapped her repeatedly. Rahimah thought it was all her fault because she thought she should be a better daughter. Rahimah was sad most days. She hid this from school and started to cut her arms just to feel something other than sadness or sometimes no feeling at all. School was so strange, she'd lost all her friends, she didn't understand a lot of the words and some of the children laughed at her.*

## PART 2: HOW TO USE THE PLANNING FRAMEWORK

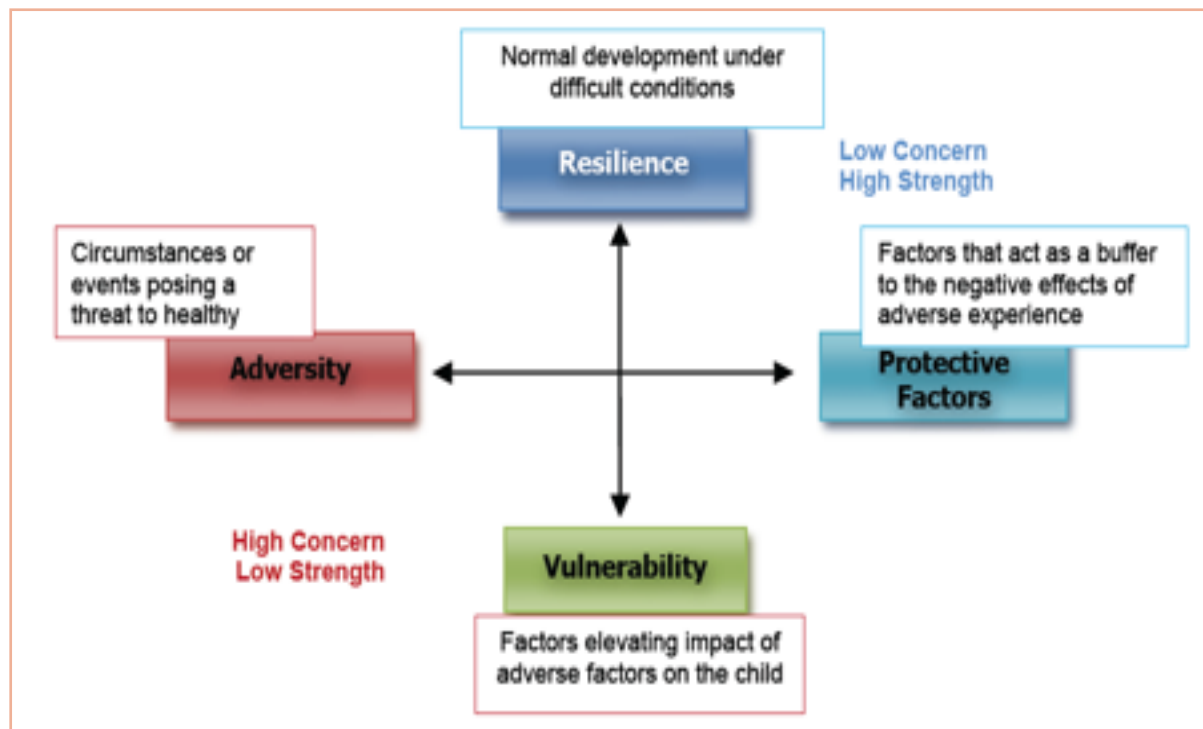
The following framework provides an understanding of how to assess and plan to address issues for refugees through resiliency theory. Put simply, resiliency refers to the human capacity to bounce back from adverse experiences. Many human beings have a remarkable capacity to withstand overwhelming adversity, while others can be sensitive to the smallest of critical comments. The framework for our local context has been developed by Dr Barron, University of Dundee, by adapting and integrating a model of resiliency developed at Dundee by Dr Brigid Daniel, into the National Child Traumatic Stress Network (NCTSN) framework for refugees. The resiliency model adopted has four main interacting factors to understanding and addressing resilience. These are protective factors, resiliency factors, adversity factors and vulnerability factors. These four interacting factors differ for each individual, family and community. The framework enables the assessment of the existence or otherwise of specific aspects of the four factors (see below). A rating scale for each specific issue enables the identification of the degree of concern as well as what needs to be strengthened, e.g. protective and resiliency factors or what needs to be reduced, e.g. adversity and vulnerability factors.

As a planning tool to identify learning needs, the framework items can be rated in terms of worker and organisations knowledge, attitudes and skills. Goals can then be identified to address these gaps in relation to each item in the framework. Depending on the agency, of course, not all items will need to be addressed.

See PART 3: Planning Framework for Addressing Refugee Experience of Acculturation and Resettlement.

### Who should complete the framework?

The framework can be completed by single or multiple agencies working together. Where a single agency completes the framework, other agencies will need to be approached for the completion of specific tasks, e.g. education may have to approach the housing department. Key staff within agencies and across agencies will need to be identified to complete the planning framework. This will need to be staff with sufficient strategic influence to enable actions to be taken within and across agencies. The framework should be completed within a review process where identified needs and tasks agreed are regularly monitored and reported. Where the framework is used as a learning framework, again the framework can be completed by individual workers or organisations to identify knowledge and skill gaps. The framework could be provided for supervisors and managers to facilitate opportunities for training.



Resiliency Framework (Daniel, Wassell and Gilligan, 2010)

## Resiliency factors

The framework covers the following main headings and subheadings:

**Protective factors.** These are environmental factors that will reduce the likelihood of symptoms and increase support and resiliency. These include secure, close relationships; good access to services; culturally sensitive services; social and community supports; communities that are aware of what may have traumatised refugees and what their symptoms might be; and access to therapy.

**Adversity factors.** These are factors in the current and past environments for refugees and include threats and dangers in their life situation; inappropriate responses from services and communities; and communities of violence and substance misuse.

**Vulnerability factors.** These tend to be factors within a person and include the extent of their traumatisation; problems with fitting into the new culture; disabilities; too many or severe daily challenges; struggling to cope with the losses in their social context; and inappropriate survival responses such as substance misuse and self-harm.

**Resilience factors.** These tend to be positive resources within the person and include the ability to develop trusting relationships; and having a sense of competence and confidence in both social and academic tasks.

In PART 3 the framework involves rating items under each of these four factors as:

- (i) What has already been done?
- (ii) What needs to be done?
- (iii) Actions, by whom, by when?
- (iv) Agencies to refer to (for action or advice)
- (v) Agencies and roles (agreed roles for the tasks required)
- (vi) Other comments (helpful comments & reminders)

## Screening and assessment of trauma

Where the above behavioural, social, emotional and health concerns are identified by families, schools, and/or other community organisations, there will be a need to screen for trauma symptoms. If these symptoms are confirmed through screening, there will be a need to conduct a more thorough trauma history assessment.

Screening for trauma symptoms requires to be administered by an appropriately qualified mental health professional. A range of screening measures for post-traumatic stress, complicated grief and co-morbid symptoms, such as depression and dissociation, are available for both children and adults, e.g. the Impact of Events Scale and the Inventory of Complicated Grief. The National Child Traumatic Stress Network and the Children and War Foundation websites are useful sources of measures translated into different languages. Screening and assessment of traumatisation is counter-indicative (can make things worse) where no trauma-specific help is subsequently provided soon after.

<http://www.nctsn.org/resources/online-research/measures-review>

<http://www.childrenandwar.org/measures/>

A trauma history assessment of traumatic events and symptoms needs to be conducted by a mental health professional specifically trained and accredited in a trauma recovery approach. Conducting trauma histories without providing a trauma therapy can be contra-indicative. A good example of a trauma history interview can be found at:

<http://www.childtrauma.com/publications/books/child-trauma-handbook/>

A structured trauma history-taking is part of Eye Movement Desensitisation Reprocessing, one of the two evidence-based approaches to addressing post-traumatic stress in children and adults.

<http://www.emdrassociation.org.uk/home/index.htm>

## Overview of support for refugees

Perhaps the bottom line is to ask ‘How would you like to be welcomed to a new country to live there for the rest of your life?’ How important is it to see smiling faces, nodding heads, to feel a gentle touch, to have a listening ear, to understand and be understood, to have money, entitlements, engage in education and/or work, to have a safe home and avoid multiple moves, to have access to health and mental health services, to begin to have friends, to



reconnect to leisure activities, to have a community that owns you and you belong to, to keep your old identity as you form a new one, to have legal representation and child protection services accessible if you need them, to be allocated a social worker (long term if need be), to be taught the language, to learn to write in a new language or write for the first time, to learn the customs, to walk safely down the street, to be able to sleep at night, to be in a stable place – to be human and to be treated as such.

Trauma recovery means all the above needs to be addressed, otherwise it is difficult for children and families to engage in the difficult work of processing past traumas and current stressors in therapy. Establishing warm relationships with others will be essential. Someone caring who can support the child throughout the process of arrival and settling in can make a big difference. Later, having someone to bear witness to past adversities and current stressors can facilitate healing. Likewise a child being helped to understand that their trauma reaction is normal, given the exceptional circumstances they have been through, can let children know they are not going mad. Confidential spaces in therapy can help children understand and work through the feelings they have, be it by talking, drawing, drama, art and more specifically brief exposure therapies (listed below). Refugees also need those who will campaign and advocate for their rights and awareness of their needs.

## Empirically based interventions

The National Institute for Health and Care Excellence currently recommends only CBT and EMDR as the two trauma-specific therapies for addressing post-traumatic symptoms. There are however a range of promising therapies such as: Progressive Counting, Sensorimotor Therapy, Narrative Exposure therapy (KidNET) for refugee children; Traumatic Incident Reduction and the old standard of Prolonged Exposure. With the latter, however, adolescents struggle to tolerate the intense emotions.

Effective trauma recovery approaches are based on ensuring:

1. That the child, adult and or family are physically and emotionally safe ‘now’ and that good attachments with safe others, especially for children, are in place.
2. Both children and adults can be taught a range of *stabilisation techniques*, e.g. imagining a safe place, that will help them calm themselves and enable them to be ‘here in the present’ instead of in a dissociated state, e.g. orienting to the room you are in.
3. For therapy to be successful, there are important core relationship factors that need to be in place. These are - empathy, positive regard, shared understanding of the problem and solution and shared planning.
4. Motivational interviewing including imagining a better future, can also be helpful in the short term to facilitate therapy.
5. Finally, there are certain characteristics to effective trauma-specific therapies. These seem to be:
  - the capacity to face the traumatic memory and not feeling overwhelmed;
  - brief rather than prolonged exposure;
  - viewing the traumatic event from an imagined distance;

- being enabled to take a broader perspective of the event including past and future perspectives;
- having an opportunity to think through for oneself;
- keeping a focus on the 'past' and the 'present';
- the option of privacy and not telling everything with shame based experiences;
- and finally healing that leads to the ability to tell a coherent narrative.

### *Stabilisation techniques*

A range of techniques are helpful in enabling children and adults to feel safe, calm and stable, especially after being triggered and emotionally dysregulated. Stabilisation techniques include psycho-education, that is, helping the child and parent/carer understand that the child's symptoms are normal given what has happened to them. The relationship between traumatic events and post-traumatic stress symptoms are explained. Children can be taught how to recognise triggers and symptoms and how to reduce these. Trauma focused-CBT, for example, has a wide range of strategies to help children cope with flashbacks, hyperarousal, avoidance and grief symptoms.

### *Support groups*

Because of the many challenges refugees face, connecting up with other refugees may be a supportive experience for some. This is especially true where experiences are similar. Support groups offer one way refugees can reconnect with their culture, express their concerns and explore solutions to the many difficulties they have to face. The Scottish Refugee Council may be able to support the connecting up of refugees (see agency section). Local authorities and local charities may be helpful in helping establish support groups for refugees.

### *Approaches and websites*

#### **1. Eye Movement Desensitisation and Reprocessing (EMDR)**

EMDR is one of the two evidence based approaches to processing traumatic events.

<http://www.emdrassociation.org.uk/home/index.htm>

#### **2. Narrative Exposure Therapy**

Narrative exposure is one of the few trauma recovery approaches to have been developed with refugees.

<http://www.hogrefe.com/program/narrative-exposure-therapy.html>

#### **3. Progressive Counting**

Progressive counting developed from EMDR as a brief exposure therapy that uses counting rather than eye movements or bilateral stimulation.

<http://www.childtrauma.com/publications/books/progressive-counting/>

#### **4. Sensorimotor Therapy**

Sensorimotor therapy is a body oriented therapy for processing traumatic events.

<https://www.sensorimotorpsychotherapy.org/home/index.html>

#### **5. Trauma-focused cognitive behavioural therapy (TF-CBT)**

Trauma-focused cognitive behavioural therapy is one of the evidence based trauma recovery approaches that is more widely available in Scotland than EMDR.

<https://tfcbt.org/>

#### **6. Traumatic Incident Reduction**

Traumatic Incident Reduction is another brief exposure therapy (please follow link).

<http://www.tir.org/about-tir.html>

#### **7. Prolonged Exposure**

Prolonged exposure used to be the gold standard for trauma event processing before EMDR developed an evidence base. Children and adolescents found the strong emotions that emerge through prolonged exposure difficult to cope with.

<http://www.ptsd.va.gov/public/treatment/therapy-med/prolonged-exposure-therapy.asp>

#### **8. Dyadic Developmental Psychotherapy**

For children and adolescents who have experienced cumulative domestic violence where attachments have been ruptured, exposure therapies often need to be set within approaches to facilitating attachment. The Dyadic Developmental Psychotherapy (DPP) webpages have many useful ideas.

<http://ddpnetwork.org/>

#### **9. Dialectical Behaviour Therapy**

A therapy for adolescents who have been multiply abused is Dialectical Behaviour Therapy (DBT), an approach based on cognitive behavioural therapy for adolescents and adults who are emotionally reactive and experience intense emotions. DBT is used within some of the facilities in Scotland's Secure Accommodation.

<http://psychcentral.com/lib/an-overview-of-dialectical-behavior-therapy/>

## Useful Resources

### *Agencies*

The following agencies provide advice on identifying and meeting the needs of refugees. Most offer helpful information through their websites.

**EMDR UK and Ireland** <http://www.emdrassociation.org.uk/home/index.htm>  
EMDR provides a range of advice on traumatisation and recovery.

**Suicide Prevention Scotland and UK** <http://www.chooselife.net/>  
and <https://www.papyrus-uk.org/>  
Suicide prevention Scotland provides helpful information on strategies and supports.

**Refugee council** <http://www.refugeecouncil.org.uk/>  
These webpages cover a wide range of issues and services for refugees.

**Refugee Action** <http://www.refugee-action.org.uk/>  
Focus on newly arrived refugee issues.

**Migrant help** <http://www.migranthelpuk.org/>  
Provides information for the most vulnerable migrants.

**Asylum Aid** <http://www.asylumaid.org.uk/>  
A route to free legal advice.

**UNHCR** <http://www.unhcr.org/uk/>  
International projects to protect refugees.

**Salvation Army** <http://www.salvationarmy.org.uk/>  
Provides a wide range of social welfare services.

**Scottish Refugee Council** <http://www.scottishrefugeecouncil.org.uk/>  
The Scottish organisation of the refugee council.

### *Books for professionals*

These are two books that focus on firstly understanding the nature of child traumatisation, and secondly setting trauma and recovery within the context of refugees.

Bessel van der Kolk's book (2015) '**The Body Keeps the Score**' is essential reading for child traumatisation. <http://www.amazon.co.uk/The-Body-Keeps-Score-Healing/dp/0670785938>

Broken Spirits: '**The Treatment of Traumatised Asylum Seekers, Refugees, and War and Torture Victims**' provides a range of expert perspectives on a complex subject.  
<https://books.google.co.uk/books?isbn=1135946426>

## *Webpages*

The following pages cover considerable information on the nature of trauma and refugees.

Children and War Foundation

<http://www.childrenandwar.org/>

National Child Traumatic Stress Network

<http://www.nctsn.org/>

National Institute for Health and Care Excellence

<https://www.nice.org.uk/>

Roads to Refuge

[http://www.roads-to-refuge.com.au/whois/whois\\_definitions.html#refugees](http://www.roads-to-refuge.com.au/whois/whois_definitions.html#refugees)

UN Refugee Agency

<http://www.unhcr.org.uk/>

## *Video material on refugees*

Youtube provides an incredible amount of material on refugees.

[https://www.youtube.com/results?search\\_query=refugee+trauma](https://www.youtube.com/results?search_query=refugee+trauma)

Refugee true stories at:

[http://www.redcross.org.uk/What-we-do/Refugee-support/Refugees-true-stories\\_](http://www.redcross.org.uk/What-we-do/Refugee-support/Refugees-true-stories_)

## *Refugees and interpreters*

Helpful information at:

<http://www.refugeelegalaidinformation.org/interpreters-and-language-refugee-settings>

## Evaluating the framework

Most initiatives are unfortunately adopted on trust, rather than based on evidence. It is important that the planning framework is properly evaluated and adapted as necessary. Please contact Dr Ian Barron to be part of the ongoing development and evaluation of this planning framework. Email: [i.g.z.barron@dundee.ac.uk](mailto:i.g.z.barron@dundee.ac.uk)

## Training to support framework implementation

Training is available from Dr Ian Barron, University of Dundee on the nature of trauma exposure, resultant symptomology, screening, assessment, creating trauma sensitive milieu and intervention, and how to use the framework. Please contact Dr Barron directly: email [i.g.z.barron@dundee.ac.uk](mailto:i.g.z.barron@dundee.ac.uk) and Tel: 01382 381479.

The One World Centre offers value based training sessions and resources on a wide range of refugee, global and environmental issues. Please make direct contact to receive a list of trainings including trainings by other related organisations/with the One World Centre, 189 Princes Street, Dundee, DD4 6DQ, Tel. 01382 454603, Email: [admin@oneworldcentre.org.uk](mailto:admin@oneworldcentre.org.uk).

## PART 3: REFUGEES AND RESILIENCY

### AN INTER-PROFESSIONAL PLANNING FRAMEWORK FOR ADDRESSING REFUGEE EXPERIENCE OF ACCULTURATION AND RESETTLEMENT

Factor	What has already been done?	What needs to be done?	Actions By whom? By when?	Agencies to refer to	Agencies and roles	Other comments
<b>Protective Factors</b>						
<b>Basic needs &amp; access to services</b> <ul style="list-style-type: none"> <li>• Stable and safe housing</li> <li>• Access to medical, mental health &amp; dental care services</li> <li>• Enrolled and attending school/education</li> <li>• Sustainable &amp; sufficient employment/income</li> <li>• Financial assistance if necessary for food, heating, transportation, clothes</li> <li>• Access to affordable legal services</li> <li>• Monitoring and support from social services and assessment of future service need</li> <li>• Named Person identified</li> <li>• Support person/Advocate (non-statutory)</li> </ul>						
<b>Cultural sensitivity</b> <ul style="list-style-type: none"> <li>• Culturally informed and sensitive services (understand child's country of origin culture and customs, meanings)</li> <li>• Language learning and tuition</li> <li>• Interpreters and cultural brokers available to enable interaction between services and family</li> <li>• Opportunities to learn about Scottish and local culture</li> </ul> <b>Social and community supports</b> <ul style="list-style-type: none"> <li>• Supportive family relationships and good communication</li> <li>• Involvement in clubs and hobbies</li> <li>• Supportive peers in school and community</li> <li>• Helpful and inclusive communities</li> <li>• Connection to religious &amp;/or cultural communities of country of origin, including mentoring</li> </ul>						

<b><i>Traumatisation and recovery</i></b> <ul style="list-style-type: none"> <li>• Screening and assessment of traumatisation</li> <li>• Awareness of nature and extent of past traumatic events</li> <li>• Mental health services for traumatisation (e.g. EMDR/TF-CBT)</li> <li>• Psycho-education of trauma as normal response to adversity, set within developmental responses</li> <li>• Reduce triggers/reminder in environment(s)</li> </ul>						
<b>Adversity factors</b>						
<b><i>Life situation</i></b> <ul style="list-style-type: none"> <li>• Alienation and treated with mistrust</li> <li>• Loneliness &amp; Isolation, lack of friends</li> <li>• Ongoing violence or threat of community violence</li> <li>• Domestic violence</li> <li>• Unemployment</li> <li>• Homelessness</li> <li>• Criminality and substance misuse</li> </ul>						
<b><i>Response from services</i></b> <ul style="list-style-type: none"> <li>• Discrimination, prejudice, harassment &amp; other micro-aggression, including from police and other societal institutions, e.g. UKVI</li> </ul>						
<b>Vulnerability factors</b>						
<b><i>Traumatisation</i></b> <ul style="list-style-type: none"> <li>• Previous traumatisation</li> <li>• Posttraumatic stress</li> <li>• Signs of developmental trauma</li> <li>• Known/unknown trauma triggers</li> <li>• Emotional dysregulation</li> <li>• Complicated grief symptoms (more like PTSD)</li> <li>• Co-morbid symptoms such as depression and anxiety</li> </ul>						
<b><i>Acculturation problems</i></b> <ul style="list-style-type: none"> <li>• difficulties adapting into new school</li> <li>• parent/child conflicts about old and new values</li> <li>• peer conflict resulting from differing cultural beliefs</li> <li>• child having to translate for parents</li> <li>• child as carer</li> <li>• child as wage earner</li> <li>• struggling with old and new identities</li> </ul>						
<b><i>Disabilities</i></b> <ul style="list-style-type: none"> <li>• Learning difficulties</li> <li>• Physical disabilities</li> <li>• Emotional and behavioural difficulties</li> <li>• Diagnosed condition(s)</li> <li>• Additional support needs unmet</li> </ul>						

<b>Daily challenges</b> <ul style="list-style-type: none"> <li>• Problems with finances</li> <li>• Schooling</li> <li>• Travel</li> <li>• Little community support</li> <li>• Parenting</li> <li>• Bullying / discrimination</li> </ul>						
<b>Losses in social context</b> <ul style="list-style-type: none"> <li>• Social standing/status</li> <li>• Friends and family</li> <li>• Schooling</li> <li>• Identity</li> <li>• Community</li> </ul>						
<b>Inappropriate survival responses</b> <ul style="list-style-type: none"> <li>• Engaging in risky behaviours, e.g. substance misuse, self-harm</li> <li>• Gang related activities</li> <li>• Risk of suicide</li> <li>• Avoidance of school, support and services</li> </ul>						
<b>Resiliency factors</b>						
<ul style="list-style-type: none"> <li>• Secure attachments/good relationships</li> <li>• Sense of self-worth, respect and self-esteem</li> <li>• Sense of competence and confidence socially</li> <li>• Sense of competence &amp; confidence academically</li> <li>• Opportunities for social, leisure and learning experiences, to build competence and confidence</li> </ul>						



# **APPENDIX 1: RISK, VULNERABILITY, PROTECTIVE & RESILIENCE FACTORS FOR SUICIDE WITH CHILDREN AND ADOLESCENT REFUGEES**

## **Risk and vulnerability factors**

Risk and vulnerability factors can interact to increase the likelihood of children and adolescents making suicide attempts. Risk is difficult to assess and predict, for example, risk may be increased by something small, a put down comment, which may be a trigger for considerable underlying misery. For others, risk may come from a series of experiences that overwhelm the child or adolescent. Examples of risk and vulnerability include:

- Previous suicide attempts
- Suicide in the family
- Family conflict
- Family unemployment
- Peer relationship difficulties, including bullying
- Previous or current incarceration, e.g. secure accommodation, kidnap and torture
- Alcohol and substance misuse
- Past multiple life stressors interacting with current multiple life stressors
- Problems managing emotions, especially anger, anxiety and fear
- Depression and hopelessness

## **Protective and resilience factors**

Protective and resilience factors are those factors that interact to prevent and reduce the risk of suicide in the first place, or where attempts at suicide have been made, reducing the likelihood of further attempts at suicide. Factors can include:

- Good attachments and supportive family relationships
- At least one caring and physically and emotionally available adult
- Strong cultural beliefs that are affirmed by own community and receiving community
- Deeply held religious beliefs, including use of spiritual practices for coping
- Welcoming peer group(s) and contact with own cultural supportive peer group
- Developed or opportunity to develop opportunities to boost sense of competence and confidence. This can include social and academic activities
- Activities and relationships that instil a sense of hope that the future will be better
- Responsive and supportive educational, medical and psychological help